



Benefits and Premiums are effective January 1, 2022 through December 31, 2022

SUMMARY OF BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.	
Annual Deductible	\$0	\$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.		
Annual Maximum Out-of-Pocket Amount	Network Services:	Network and out-of-network services:
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	\$2,750	\$5,500 for in and out-of-network services combined
It will apply to all medical expenses except Hearing Aid Reimbursement that may be available on your plan.		



HOSPITAL CARE*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Inpatient Hospital Care	\$500 per stay	25% per stay
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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Observation Care	Your cost share for Observation Care is based upon the services you receive.	
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Outpatient Services & Surgery	15%	25%
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Ambulatory Surgery Center	15%	25%
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PHYSICIAN SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Primary Care Physician Visits	15%	25%
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Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.

Physician Specialist Visits	15%	25%
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PREVENTIVE CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Medicare-covered Preventive Services	\$0	25%
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- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.
- Depression screenings
- Diabetes screenings
- HBV infection screening



- Hepatitis C screening tests
- HIV screenings - annually for patients younger than 15 and adults older than 65 at increased risk for HIV infection
- Lung cancer screenings and counseling - Aged 55–77
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit
- Bone mass measurements \$0 25%
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) \$0 25%
- For all members aged 50 to 85 years
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes. \$0 25%

Immunizations 0% 0%

- Flu
- Hepatitis B
- Pneumococcal

Additional Medicare Preventive Services 0% 25%

- Barium enema - one exam every 12 months.
- Diabetes self-management training (DSMT)
- Digital rectal exam (DRE)
- EKG following welcome exam
- Glaucoma screening



EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Emergency Care; Worldwide (waived if admitted)	\$50	\$50
Urgently Needed Care; Worldwide	\$35	\$35
DIAGNOSTIC PROCEDURES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Diagnostic Radiology MRI and CT scans	15%	25%
Lab Services	15%	25%
Diagnostic testing & procedures	15%	25%
Outpatient X-rays	15%	25%
HEARING SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Hearing Screening We cover one every twelve months	0%	25%
Medicare Covered Hearing Examination	15%	25%
Hearing Aid Reimbursement Applies to in or out of network	\$1,000 once every 36 months	
DENTAL SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Covered Dental* Non-routine care covered by Medicare.	15%	25%



VISION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Routine Eye Exams One annual exam every 12 months.	0%	25%
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Diabetic Eye Exams	0%	25%
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MENTAL HEALTH SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$500 per stay	25% per stay
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Outpatient Mental Health Care Individual visit	15%	25%
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Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$500 per stay	25% per stay
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Outpatient Substance Abuse Individual visit	15%	25%
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SKILLED NURSING SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Skilled Nursing Facility (SNF) Care	0% per day, days 1-20; 15% per day, days 21-100	25% per day, days 1-100
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Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.



PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	15%	25%
AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Ambulance Services	15%	25%
Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.		
TRANSPORTATION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Transportation (non-emergency)	Not Covered	
MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Part B Prescription Drugs	0%	25%



ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Blood	All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	15%	25%
Chiropractic Services*	15%	25%
Medicare covered benefits only.		
Diabetic Supplies*	0%	25%
Includes supplies to monitor your blood glucose from LifeScan.		
Durable Medical Equipment/ Prosthetic Devices*	15%	25%
Home Health Agency Care*	0%	25%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Outpatient Dialysis Treatments*	15%	15%
Podiatry Services	15%	25%
Medicare covered benefits only.		
Pulmonary Rehabilitation Services	15%	25%
Radiation Therapy*	15%	25%



ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Fitness Benefit	SilverSneakers	
Resources For Living[®] For help locating resources for every day needs.	Covered	
Teladoc[™] Telemedicine services with a Teladoc [™] provider. State mandates may apply.	15%	
Telehealth Telemedicine Services. Member cost share will apply based on services rendered.	Covered	
Telehealth PCP	15%	25%
Telehealth Specialist	15%	25%
Telehealth Other Health care Providers	15%	25%
Telehealth Individual Mental Health	15%	25%
Telehealth Group Mental Health	15%	25%
Telehealth Individual Psychiatric Services	15%	25%
Telehealth Group Psychiatric Services	15%	25%
Telehealth Urgent care	\$35	\$35
ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Physical Exams One exam per calendar year	0%	25%

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Medical Disclaimers

For more information about Aetna plans, go to www.AetnaRetireePlans.com or call Member Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Not all PPO Plans are available in all areas



The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.



Plan Disclaimers

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

You can read the *Medicare & You 2022* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711).

Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711)。

You can also visit our website at <http://www.aetnaretireplans.com>. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

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